12 4129

JD

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

LOUIS C. SHEPTIN,

PLAINTIFF

(In the space above enter the full name(s) of the plaintiff(s).)

- against -

CARDINET
227 WASHINGTON ST.
CONSHOHOCKEN, PA
19428,

DEFENDANTS

(In the space above enter the full name(s) of the defendant(s). If you cannot fit the names of all of the defendants in the space provided, please write "see attached" in the space above and attach an additional sheet of paper with the full list of names. The names listed in the above caption must be identical to those contained in Part I. Addresses should not be included here.)

COMPLAINT

Jury Trial: ☑ Yes ☐ No

(check one)

I. Parties in this complaint:

A. List your name, address and telephone number. If you are presently in custody, include your identification number and the name and address of your current place of confinement. Do the same for any additional plaintiffs named. Attach additional sheets of paper as necessary.

Plaintiff	Name	LOUIS C. SHEPTIN
	Street Address	72 17TH ST ROOM 417
	County, City	SAN DIEGO, CALIFORNIA 92101
	State & Zip Code	92101
	Telephone Number	619 (795 8012)

B. List all defendants. You should state the full name of the defendants, even if that defendant is a government agency, an organization, a corporation, or an individual. Include the address where each defendant can be served. Make sure that the defendant(s) listed below are identical to those contained in the above caption. Attach additional sheets of paper as necessary.

Defendant No. 1
Name CARDIONET INC
Street Address 227 RONSHOCKEN PA
County, City
State & Zip Code PENNSYLVANIA 19428

Defendant No. 2
Name
Street Address
County, City
State & Zip Code

Defendant No. 3
Name
Street Address
County, City
State & Zip Code

Defendant No. 4
Name
Street Address
County, City
State & Zip Code

II. Basis for Jurisdiction:

Federal courts are courts of limited jurisdiction. Only two types of cases can be heard in federal court: cases involving a federal question and cases involving diversity of citizenship of the parties. Under 28 U.S.C. § 1331, a case involving the United States Constitution or federal laws or treaties is a federal question case. Under 28 U.S.C. § 1332, a case in which a citizen of one state sues a citizen of another state and the amount in damages is more than $75,000 is a diversity of citizenship case.

A. What is the basis for federal court jurisdiction? *(check all that apply)*

☑ Federal Questions ☑ Diversity of Citizenship

B. If the basis for jurisdiction is Federal Question, what federal Constitutional, statutory or treaty right is at issue? 42 USC 1983; FEDERAL CONSUMER PROTECTION ACT; DIVERSITY; FALSE CLAIMS ACT; WHISTLEBLOWER ACT

C. If the basis for jurisdiction is Diversity of Citizenship, what is the state of citizenship of each party?

Plaintiff(s) state(s) of citizenship CALIFORNIA

Defendant(s) state(s) of citizenship PENNSYLVANIA (PRINCIPAL PLACE OF BUSINESS)

III. Statement of Claim:

State as briefly as possible the facts of your case. Describe how each of the defendants named in the caption of this complaint is involved in this action, along with the dates and locations of all relevant events. You may wish to include further details such as the names of other persons involved in the events giving rise to your claims. Do not cite any cases or statutes. If you intend to allege a number of related claims, number and set forth each claim in a separate paragraph. Attach additional sheets of paper as necessary.

A. Where did the events giving rise to your claim(s) occur? CALIFORNIA AND PENNSYLVANIA, AND ARIZONA (MONITOR WAS SENT FROM ARIZONA).

B. What date and approximate time did the events giving rise to your claim(s) occur? JUNE 12, 2012, JUNE 18, 2012 WHEN PLAINTIFF REPORTED DEFECTIVE HEART MONITOR BUT DEFENDANT DID NOT REPLACE IT OR REPAIR IT.

What happened to you?

C. Facts: ON OR ABOUT JUNE 12, 2012 I RECEIVED VIA A UPS SHIPMENT A CARDIAC EVENT MONITOR FROM ONE "FRED BITTNER" IN ARIZONA. PLAINTIFF HAS SIGNIFICANT CORONARY DISEASE WITH 11 (ELEVEN STENTS IMPLANTED), A FIB-FLUTTER, DIABITIES TYPE II, SEIZURES AND A HOST OF OTHER INFIRMITIES. THIS MONITER

Who did what?

WAS ORDERED BY CARDIOLOGIST BRUNO COTTER. CARDIONET SENT WITH THE MONITER A WARNING NOTICE WRITTEN IN BOTH ENGLISH AND SPANISH THAT PLAINTIFF WOULD BE CHARGED $1000.00 (IN ENGLISH)

Was anyone else involved?

IF THE MONITER WAS NOT RETURNED (IN SPANISH $450.00) **SEE EXHIBIT "A"** THIS PUBLISHED DOCUMENT WHICH WAS PUBLISHED BY DEFENDANT DISCRIMINATED AGAINST THIS SERIOUSLY ILL PLAINTIFF/AMERICAN

Who else saw what happened?

WHO UNDERWENT ANGIOPLASTY ON JUNE 28, 2012 AND HAD A STROKE ON JULY 3, 2012. PLAINTIFF SUFFERED SEVERE EMOTIONAL DISTRESS FROM A CARDIAC MONITER WHICH ALARMED WHEN IT WAS NOT EVEN ATTACHED TO PLAINTIFF'S CHEST. MONITER DID NOT WORK AS EVIDENCED BY EXHIBITS B AND C. IT WAS REPORTED 3 TIMES TO CARDIONET

CONTINUED TO READ A BETTER MONITOR
MONITOR WAS ORDERED FOR 30 DAYS JUNE 12 TO JULY 12, 2012

IV. **Injuries:**

MEDICAL RECORDS: EXHIBITS B AND C.

If you sustained injuries related to the events alleged above, describe them and state what medical treatment, if any, you required and received. PLAINTIFF UNDERWENT ANGIO PLASTY ON JUNE 28, 2012 AND HAD A STROKE ON JULY 3, 2012 SEE EXHIBITS B AND C. EMOTIONAL DISTRESS FROM DISCRIMINATORY PAPERWORK SENT WITH DEVICE. BECAUSE OF MANY DISCREPANCIES IN CARDIONET'S "ADDRESS", PHONE NUMBERS (IE: 1-877-921-7000 ALWAYS BUSY PHONE NUMBER FOR REED BITTNER); SAN DIEGO 1010 2ND AVE 619 243-7700 (NOT IN SERVICE). THERE ARE CONCERNS ABOUT THE LEGITIMARY OF THIS FIRM AND FALSE CLAIMS. (SEE US VERSUS LIFEWATCH SEATTLE, WA FED COURT)

V. **Relief:**

FALSE CLAIMS AS IN MEDICAID FRAUD.

State what you want the Court to do for you and the amount of monetary compensation, if any, you are seeking, and the basis for such compensation.

1) PUNITIVE DAMAGES FOR DISCRIMINATION OF $100,000.00 PUBLISHED DOCUMENT
2) POSSIBLE RULE 23 CLASS ACTION CERTIFICATION
3) PUNITIVE DAMAGES UNDER DIVERSITY $200,000.00
4) COMPENSATORY DAMAGES ONE MILLION DOLLARS
5) COST OF COURT ATTORNEY FEES SUCH COSTS AND FURTHER RELIEF THIS HONORABLE COURT DEEMS JUST PROPER AND EQUITABLE.
6) APPOINTMENT OF COUNSEL.
7) INVESTIGATE FOR MEDICARE/MEDICAID FRAUD.

1/ FOR SANDIEGO AND PHOENIX
2/ MONITER DID NOT WORK. A CONSENSUAL RECORD PHONE CALL WAS MADE JUNE 18, 2012 AT 3:43 PM REPORTING DEFECTIVE MONITER. TECH STATED MONITOR ACTED "BIZARR" BUT REFUSED TO REPLACE MONITER OR SENT NEW ONE.

I declare under penalty of perjury that the foregoing is true and correct.

Signed this 13 day of July, 2012.

Signature of Plaintiff [signature]

Mailing Address 7212 17th St Room 417
San Diego CA 92101

Telephone Number 619 795 [redacted] 8012

~~Fax Number~~ *(if you have one)* 619 795 8012

E-mail Address

Note: All plaintiffs named in the caption of the complaint must date and sign the complaint. Prisoners must also provide their inmate numbers, present place of confinement, and address.

For Prisoners:

I declare under penalty of perjury that on this 13 day of July, 2012, ~~I~~ am delivering this complaint to ~~prison authorities to be mailed to the~~ Clerk's Office of the United States District Court for the Eastern District of Pennsylvania.

Signature of Plaintiff: [signature]

~~Inmate Number~~ NONE

i2 4[illegible]

UNIVERSITY of CALIFORNIA, SAN DIEGO
MEDICAL CENTER

Sulpizio Cardiovascular Center
9434 Medical Center Dr. La Jolla Ca. 92093 TEL: 858-657-8815 FAX: (858)657-8814

JD

$1,000.00

FA

To:

Re:

Fro

Nu

Co

IMPORTANT MESSAGE!

While we hope that this device is helpful to you, please note that it is not yours to keep. It is your responsibility to return it at the end of your study.

To avoid being billed $1000.00 for this device, it is important that the device be returned at the end of your study. period. This device is included for use during your study, but please note that IT MUST BE RETURNED. All supplies are included and cost of shipping are prepaid by the company. We thank you for your help on this matter.

Steps:

1. After your 30 day testing period ends, place all remaining supplies and the recording device back in the hard case provided to you.
2. Place the hard case into the provided US MAIL mailer.
3. Drop in any US Mail BOX (even the one at your home) immediately after your study period ends.

If the device is not received by CardioNet within 10 days of the end of the study period, you will be billed. We Thank You for your help.

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CARDIONET

Customer Service Phone Number:
1-866-744-4677

1010ES Rev 0212

— SEE REVERSE —

FLIP OVER FOR SPANISH SIDE

EXHIBIT A

PHYSICAL EVIDENCE RECEIVED BY PLAINTIFF FROM CARDIONET

EXHIBIT "A"

Please Note: Discharge date is for Inpatients only. For Outpatients, the discharge date is the encounter closing date.

Admission Date	Discharge Date	Discharge Disposition
06/27/2012	06/28/2012	Routine Discharge

Op Note filed by Dominguez, Arturo, MD at 07/05/12 0849 / Draft: Not Electronically Signed

Author:	Dominguez, Arturo, MD	Service:	(none)	Author Type:	Fellow
Filed:	07/05/12 0849	Note Time:	06/27/12 1833		

Dictating Practitioner: Arturo Dominguez, M.D.

Staff Physician: Sotirios Tsimikas, M.D.

Date of Operation: 06/27/2012

PREOPERATIVE DIAGNOSIS: Chest pain and abnormal stress test.

POSTOPERATIVE DIAGNOSIS: Hemodynamically significant lesion by fractional flow reserve involving the mid left anterior descending, status post successful percutaneous coronary intervention with 3 drug-eluting stents to the left anterior descending.

PROCEDURES PERFORMED
1. Conscious sedation.
2. Coronary angiography.
3. Left heart catheterization.
4. Percutaneous coronary intervention with drug-eluting stents to the left anterior descending.
5. Fractional flow reserve of the proximal, mid and distal left anterior descending and left circumflex.
6. Angio-Seal closure device deployment.
7. Supervision and interpretation of the above.

SURGEON/STAFF: Sotirios Tsimikas, MD.

ASSISTANT/FELLOW: Arturo Dominguez, MD.

HISTORY OF PRESENT ILLNESS/INDICATION FOR PROCEDURE: Mr. Sheptin is a 63-year-old gentleman with a history of diabetes, atrial fibrillation, hepatitis C, seizure disorder, CAD, status post multiple PCIs, reports a total of 8coronary stents, and abnormal stress test showing 5% reversibility in the inferior basilar wall and also in the anterolateral wall, a total of 10% of the myocardium, EF 69% by MIBI.

PROCEDURE IN DETAIL: The patient was brought to the catheterization lab in the fasting state. The right groin was prepped and draped in the usual sterile fashion, and 5 mL 1% lidocaine was used for local anesthesia. A 6-French sheath was placed in the right common femoral artery using the modified Seldinger technique. A limited iliofemoral angiogram showed the arteriotomy site was above the bifurcation without evidence of dissection or extravasation of contrast.

The JL4 and JR4 diagnostic catheters were used to selectively engage the left and right coronary arteries, respectively. Selective left and right

EXHIBIT B

coronary angiograms were performed. The FR4 catheter was used to obtain a left ventricular end-diastolic pressure. It was advanced across the aortic valve over a wire.
After completion of the case, we saw mid 60%-70% LAD disease in the mid vessel distal to the stents; and also 50% mid circumflex disease. We then proceeded with FFR of the LAD lesion. The Wiseguide 6-French FL catheter was used to selectively engage the left coronary artery and the Radi wire was used to cross the mid LAD lesion. After confirming adequate position of the pressure wire several doses of intracoronary adenosine were given and the FFR of the LAD was 0.74 distally, 0.88 in the mid portion prior to the stents, and then 0.95 at the proximal portion. The Radi wire was then used to cross the mid cicurmflex lesion and intracoronary adenosine was given, the FFR measurement of the circumflex lesion was 0.94. After discovering hemodynamically significant lesion in the mid-distal LAD, we proceeded to percutaneous intervention.

The patient was anticoagulated with bivalirudin. The Wiseguide 6-French FL catheter was used to selectively engage the left coronary artery, the pressure wire was remooved and a BMW wire was used to cross the lesion. The 2.5 x 20 Maverick balloon was used to predilate the mid LAD. Subsequently, we first attempted to use a 2.5 x 28 Xience stent. However, we were not able to cross into the mid LAD given the significant tortuosity in the proximal LAD. We then placed a Whipser wire as a buddy wire and used a 2.5 x 12 Xience stent deployed at 16 atmospheres to the distal LAD, followed by a 2.5 x 12 Xience to the mid LAD, and another 2.5 x 12 Xience to the mid LAD. All of these were deployed at 16 atmospheres and post dilated with the stent balloon. We then performed angioplasty with a low pressure inflation a the proximal edge of the old mid LAD stents due to very focal 60% stenosis which may have limited inflow to distal LAD using the Xience stent balloon.

The patient tolerated the procedure well. Several angiogram showed no evidence of dissection, there was TIMI 3 flow, and no evidence of perforation at the distal wire tip. The stents appeared well apposed. Then we removed the 6-French sheath and a 6F Angio-Seal closure device was successfully deployed. The patient tolerated the procedure well.

COMPLICATIONS: None.

TOTAL CONTRAST GIVEN: 225 mL of both Omnipaque and Visipaque were used

TOTAL FLUOROSCOPY TIME: 6.6 minutes.

FINDINGS: Central aortic pressure 110/70 with a mean of 80. Left ventricular end-diastolic pressure 16.

Coronary anatomy: The left main had a distal eccentric 40%-50% plaque, uncharged from prior angiogram. It bifurcates into the LAD and left circumflex. The LAD is a large-caliber transapical vessel. It has proximal and mid stents, with stents within stents. The mid portion of the LAD has 60%-70% stenosis and the distal portion 70%-80% stenosis just distal to the stents in the mid portion in both the areas of multiple stents. The proximal portion of the LAD has minimal ISR. The circumflex has proximal and mid stents. There is an area of 50% stenosis at the mid segment of the circumflex. The circumflex provides a moderate-size OM branch that has luminal irregularities. The RCA is a large-caliber, dominant vessel. It has stents within the proximal and mid portion. There is minimal 20%-30% ISR, and there is mid and distal 20%-30% diffuse disease. The PDA is a moderate-size vessel with luminal irregularities. The PL branch was a small-caliber vessel with luminal irregularities.

FFR:
1. The FFR of the left circumflex was 0.94.
2. FFR of the LAD at the distal portion was 0.74, the midportion 0.88 prior to the mid stents and in the proximal portion across the left main, 0.95.

INTERVENTIONAL FINDINGS: The lesion in the mid-distal LAD had pre- diameter stenosis of 70%-80%. TIMI 3 flow pre-stenting. Post stent is 0%. Post stent flow was TIMI 3. The lesion is a C lesion. It was treated with 3 Xience 2.5 x 12 mm stents allof which were deployed at 16 atmospheres, post dilated at 16 atmospheres with the stent balloon. No separate balloon was used for post-dilation.

The proximal portion of the LAD had a 60% to 70% stenosis prior to the stent. This was treated with angioplasty using the Xience 2.5x12 mm stent balloon. No stent was placed in this area. It was inflated to 16 atmospheres. TIMI flow was 3 pre- and the pre-treatment stenosis was 60% to 70%. Post-angioplasty stenosis was 0% with TIMI 3 flow.

Bivalirudin was used for anticoagulation with a peak ACT >250.

IMPRESSION
1. Two vessel coronary artery disease with moderate disease in the mid circumflex and hemodynamically significant lesion in the left anterior descending confirmed by fractional flow reserve
2. Successful percutaneous coronary intervention to the mid and distal left anterior descending with 3 Xience drug-eluting stents.
3. Successful angioplasty to the proximal/mid left anterior descending.

RECOMMENDATION: The patient will be admitted to the Cardiology service. He will continue on clopidogrel and he will have standard groin precautions. The CCU team was informed of the above plan.

Dr. Sotirios Tsimikas was present and supervising the entire procedure.

Reviewed & Electronically Signed by:
Arturo Dominguez, M.D. 07/05/2012 08:48 A

DD: 06/27/2012 DT: 06/27/2012 06:33 P DocNo.: 2790125
AD/rlo 1017016.MC

Referring Physician:
SELF REFERRED

Primary Care Physician:
REFERRING MD UNKNOWN PCP

200 W ARBOR DR
SAN DIEGO, CA 92103

cc:

Revision history:

> 07/05/12 0849 Operative Report Revision by: Dominguez, Arturo, MD
07/05/12 0838 Operative Report Revision by: Dominguez, Arturo, MD
07/04/12 2023 Operative Report Revision by: Dominguez, Arturo, MD
06/28/12 2020 Operative Report Revision by: Dominguez, Arturo, MD
06/28/12 2019 Operative Report Revision by: Dominguez, Arturo, MD
06/27/12 1834 Operative Report Revision by: Dominguez, Arturo, MD

Please Note: Discharge date is for Inpatients only. For Outpatients, the discharge date is the encounter closing date.

Admission Date	Discharge Date	Discharge Disposition
07/04/2012	07/05/2012	Routine Discharge

Consults signed by Iragui-Madoz, Vicente J., MD at 07/04/12 1358

Author:	Iragui-Madoz, Vicente J., MD	Service:	Neurology	Author Type:	Attending Physician
Filed:	07/04/12 1358	Note Time:	07/04/12 1356		

EEG (7-4-2012)

This stat EEG was performed in a 63 yo male with pmh CAD s/p stents x 11, atrial fib, HLD, and seizure d/o who yesterday at 4 p.m.experiecded left-sided weakness while watching TV causing gait difficulty. The patient was brought to the ED where he was observed to have a seizure with eye fluttering, left arm shaking and unresponsiveness x 2 minutes with little or no postictal period. Neuro exam today in ED showed dysarthria, left face, arm>leg weakness. Impression: right MCA stroke vs. lacunae stroke vs. seizure/Todd's paralysis. Do EEG to assess. Sleep: 2 hours

Medications: Insulin, Crestor, Digoxin, Betapace, Labetolol, Ambien

Report.
During wakefulness, Persistent, rhythmic, medium amplitude, generalized 9 Hz potentials are observed with symmetrical distribution, maximal in amplitude over the posterior head regions. They attenuate with eye opening. Low amplitude beta activity is seen in the anterior head regions. Eye movement artifacts and occasional muscle artifacts contaminate the tracing. Drowsiness is associated wit rolling eye movements, attenuation of the posterior dominant rhythm an appearance of theta potentials. In stage II of sleep, vertex waves, sleep spindles and K complexes occur on a background of theta and delta potentials. Hyperventilation and photic stimulation were not done.

Interpretation.
Normal EEG during wakefulness and sleep stages I and II. No epileptiform discharges or changes suggestive of postictal state were observed.

Vicente Iragui, MD, PhD

Please Note: Discharge date is for Inpatients only. For Outpatients, the discharge date is the encounter closing date.

Admission Date	Discharge Date	Discharge Disposition
07/04/2012	07/05/2012	Routine Discharge

D/C Summaries signed by Sabouri, Amir Hossein, MD at 07/06/12 1704

Author:	Sabouri, Amir Hossein, MD	Service:	Neurology	Author Type:	Resident
Filed:	07/06/12 1704	Note Time:	07/05/12 1628	Cosign Required:	Yes
Cosigner:	Alexander, Joshua, DO				

Patient Name: Louis Sheptin

Principal Diagnosis (*required*): Weakness of left side of body

Hospital Problem List (*required*):
No resolved problems to display.

Active Hospital Problems
Diagnoses
- *Weakness of left side of body [728.87]
- Stroke [434.91]

Resolved Hospital Problems
Diagnoses

Additional Hospital Diagnoses ("rule out" or "suspected" diagnoses, etc.):
Rule out stroke

Principal Procedure During This Hospitalization (*required*):
CT angiogram head and neck, CT head noncontrast, EEG

Other Procedures Performed During This Hospitalization (*required*):
Ultrasound of carotid, CXR

Procedure results are available in Chart Review in Epic. For those providers external to UCSD, the key procedure results are listed below:

Carotid ultrasound 7/5
- Small calcified plaques in the left carotid bulb. Otherwise, Grayscale and color images demonstrate no other evidence of calcified or soft plaque.
- The vertebral arteries exhibit normal antegrade flow bilaterally.
- No evidence of hemodynamically significant stenosis

CT angiogram head and neck 7/3
1. No definite major stenosis, occlusion or dissection of the arteries in the neck or head.
2. Mild cerebral and cerebellar volume loss. No definite infarcts are seen. No intracranial hemorrhage.
3. Moderate bilateral ethmoid sinus inflammatory disease.

EEG 7/4/12

EXHIBIT "C"

Normal EEG during wakefulness and sleep stages I and II. No epileptiform discharges or changes suggestive of postictal state were observed.

CXR 7/5/12
Mild new right mid and lower lung opacity suggests early pneumonia. No other changes noted.

CXR 7/4/12
IMPRESSION:
1. The lungs are clear.
2. The cardiomediastinal silhouettes are within normal limits.
3. No evidence of acute disease.
4. No acute osseous abnormalities noted.

Echo 6/28/12

Conclusions:
1) Normal left ventricular size and systolic function.
2) Mild concentric LV hypertrophy.
3) Moderate LV diastolic dysfunction suggesting elevated left atrial pressure.
4) Trivial pericardial effusion without evidence of tamponade.
5) Aortic sclerosis with mild-mod regurgitation.
6) Mitral valve thickened with mild regurgitation.
7) Compared to previous study on 7/25/2011, no significant change

Consultations Obtained During This Hospitalization:
Physical therapy: recommendations- hospital rehab, daily OOB, transfer, and strength training
Speech therapy: mechanical soft diet recommended

Reason for Admission to the Hospital / History of Present Illness:
63 year old male with PMH of CAD s/p 11 stents, atrial fibrillation, and seizure disorder with possible Todd's paralysis in the past presented after acute onset left sided arm and leg weakness and decreased left sided sensation. Per patient, his most recent cardiac stent was placed 1 week prior to hospitalization, and he has been on aspirin and plavix since then.

Hospital Course by Problem (*required*):
Stroke. Stroke code called in ED for acute onset L sided weakness. He was outside treatment window for tPA. Stroke workup performed. Echo had been performed at UCSD on 6/28/12 (EF was 77%) so an additional echo was not indicated. Pt declined MRI because of his recent cardiac stents, although he was cleared by radiology to undergo MRI. Is on ASA and Plavix for recent cardiac stents. Is not on coumadin despite history of atrial fibrillation due to seizure disorder. L arm weakness improved by HD 3. L leg weakness persisted.

TJC MEASURES Running Scorechart
rt-PA given (or documented why not appropriate): Contraindicated due to out of window
Dysphagia screen done (before any po medications/ food): yes
DVT Prophylaxis: Sq Heparin or SCDs yes
Carotid Imaging (done within 30 days): Yes (CUS)
Cholesterol reducing medication/Statin started (or not indicated): yes
Antithrombotic medication: on aspirin and plavix; not on coumadin 2/2 to seizure disorder
Assess for rehab needs (document if not needed): Requested rehab inpatient yes
Smoking cessation education (if smoker): yes
Stroke educations and risk factor modification given in writing: in discharge packet yes

If Atrial fibrillation patient, given coumadin: not on coumadin 2/2 to seizure disorder
Discharged on antithrombotic, lipid lowering medication (or N/A): On rosuvastatin

TTE was not repeated as there was a recent Echo on 6/28/2012 with EF: 77%

Seizure. Had a possible seizure episode in the ED. Pt had a history of possible Todd's paralysis. Was previously prescribed Dilantin but had been noncompliant. Was compliant with Tegretol. Seizure workup was completed. EEG showed no epileptiform discharge. No seizure activity throughout hospitalization. Was on Tegretol 200 mg BID. Dilantin was not given.

Cough. Per pt, had a cough with green sputum for 1 week prior to admission. Was afebrile throughout, with no leukocytosis. CXR showed possible consolidation vs. Atelectasis. Auscultation revealed mild LL lobe crackles. On HD 3, he was started on Vantin 200 mg BID for 10 days.

Hypotension. On HD 1 BP was 70s/90s and he was asymptomatic. Improved after bolus and bumex was held. BPs stable since then.

Diabetes. Blood sugar controlled with RISS.

Atrial fibrillation. Was in NSR throughout hospitalization.

Rehab. Ordered placed for FWW, home health PT, and outpatient PT.

Throughout the hospitalization, he was reluctant to have tests, wanted to leave AMA multiple times. For safer discharge, he was cleared from a medical standpoint on HD 3.

Tests Outstanding at Discharge Requiring Follow Up:
None

Discharge Condition (*required*): Stable.

Key Physical Exam Findings at Discharge:
Neurological exam improved. Strength in left arm 4/5, left leg 3/5. Sensation intact bilaterally.

Discharge Diet: Diabetic / low-carbohydrate.

Discharge Medications:
Current Discharge Medication List

START taking these medications

	Details
aspirin 81 MG chewable tablet *Associated Diagnoses:* Stroke	Take 1 tablet by mouth daily. *Qty:* 30 tablet, *Refills:* 0
carBAMazepine (TEGRETOL) 200 MG tablet *Associated Diagnoses:* Stroke	Take 1 tablet by mouth 2 times daily. *Qty:* 30 tablet, *Refills:* 0
cefpodoxime (VANTIN) 200 MG tablet *Associated Diagnoses:* Infection	Take 1 tablet by mouth every 12 hours. *Qty:* 20 tablet, *Refills:* 0
clopidogrel (PLAVIX) 75 MG tablet *Associated Diagnoses:* Stroke; CAD S/P percutaneous coronary angioplasty	Take 1 tablet by mouth daily. *Qty:* 30 tablet, *Refills:* 0

digoxin (LANOXIN) 0.125 MG tablet *Associated Diagnoses:* Arrhythmia	Take 2 tablets by mouth every evening. *Qty:* 30 tablet, *Refills:* 0
ezetimibe (ZETIA) 10 MG tablet *Associated Diagnoses:* Stroke; CAD S/P percutaneous coronary angioplasty	Take 1 tablet by mouth every evening. *Qty:* 30 tablet, *Refills:* 0
rosuvastatin (CRESTOR) 40 MG tablet *Associated Diagnoses:* CAD S/P percutaneous coronary angioplasty; Stroke	Take 1 tablet by mouth every evening. *Qty:* 30 tablet, *Refills:* 0
sotalol (BETAPACE) 120 MG tablet *Associated Diagnoses:* Stroke; Arrhythmia; CAD S/P percutaneous coronary angioplasty	Take 1 tablet by mouth every 12 hours. *Qty:* 60 tablet, *Refills:* 0
tamsulosin (FLOMAX) 0.4 MG capsule *Associated Diagnoses:* BPH (benign prostatic hyperplasia)	Take 1 capsule by mouth daily (with food). *Qty:* 30 capsule, *Refills:* 0

CONTINUE these medications which have NOT CHANGED

	Details
insulin regular (HUMULIN,NOVOLIN) 100 UNIT/ML injection	Inject 2 Units under the skin 3 times daily (before meals). Sliding Scale

Allergies:

Allergies

Allergen	Reactions
• Codeine	Unspecified
• Tetracycline	Unspecified

Discharge Disposition: Home.

Discharge Code Status: Full code / full care
This code status is not changed from the time of admission.

Follow Up Appointments:

Scheduled appointments:

Future Appointments

Date	Time	Provider	Department	Center
7/24/2012	9:30 AM	Meyer, Brett Cowan, MD	SCVNEURO	None

For appointments requested for after discharge that have not yet been scheduled, refer to the **Post Discharge Referrals** section of the After Visit Summary.

Discharging Physician's Contact Information: UCSD Medical Center operator at 619-543-6222.

Ex. B

UNIVERSITY of CALIFORNIA, SAN DIEGO
MEDICAL CENTER

5/11/2012

Re: Louis C Sheptin
72 17th St #417
San Diego CA 92101

To Whom It May concern,

Mr. Sheptin has been under my care since August 11 2010 for a complex cardiac disease. The patient has history of coronary artery disease (CAD) with multiple coronary interventions (PCI) since 1999 (RCA, LCx, LAD) and moderate left main disease disease with stable disease on last catheterization in April 2010, atrial fibrillation on solalol, congestive heart failure (CHF) with preserved left ventricular systolic function with multiple admissions for CHF exacerbation, seizure disorder, hepatitis C (failed interferon therapy) and recently diagnosed diabetes mellitus.

In my medical opinion, it would have deleterious medical effects if the patient would begin to receive medical care from a managed care provider.

If you have any questions, please call my office at 858 657 5378 for more informations.

Sincerely,

Bruno R Cotter, MD, FACC

UCSD HILLCREST MOS CARDIOLOGY | 4168 Front Street, Ste.101
San Diego CA 92103
TEL: 619-543-5743
FAX: 619-543-2917